

Appendix A

HIPAA Individual Rights PHI Request Form

Under the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), you have certain rights with respect to Protected Health Information (PHI) about you held by the Winchester Fire & Rescue Department. Our HIPAA policies require that these rights be exercised in writing. This form assists you in exercising your rights. Additional information about your rights can be found in the Notice of Privacy Practices and in our Privacy Policy and implementing regulation.

CONSENT TO RELEASE OF CONFIDENTIAL HEALTH CARE INFORMATION

Requests for copies of medical records shall be in writing, dated and signed by the requester; identify the nature of the information requested; and include evidence of the authority of the requester to receive such copies and identification of the person to whom the information is to be disclosed. The provider shall accept a photocopy, facsimile, or other copy of the original signed by the requestor as if it were an original. Within seven days of receipt of a request for copies of medical records, the provider shall do one of the following: furnish such copies to any requester authorized to receive them; inform the requester if the information does not exist or cannot be found; if the provider does not maintain a record of the information, so inform the requester and provide the name and address, if known, of the provider who maintains the record; or deny the request on the grounds that the requester has not established his authority to receive such records or proof of his identity, or otherwise provided by law. Procedures set forth in this section shall apply only to requests for records not specifically governed by other provisions of this Code, federal law or state or federal regulation.

Patient Name: _____

Provider Name: **City of Winchester Fire & Rescue Department**

Printed name of the individual or individual's personal representatives:

Relationship to individual, including authority for status as representative: _____

Please provide an accounting of disclosures of my PHI that occurred during the following period:

Date: _____ Information or Records to be disclosed: _____

As the person signing this consent, I understand that I am giving my permission to the above-named provider or other named third party for disclosure of confidential health care records. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to the person who is in possession of my records. A copy of this consent and a notation concerning the persons or agencies to which disclosure was made shall be included with my original records. The person who receives the records to which this consent pertains may not disclose them to anyone else without my separate written consent unless such recipient is a provider who makes a disclosure permitted by law.

This consent expires on (date):

Signature of Patient:

The Winchester Fire & Rescue Department is not required to grant this request

Copies of a patient's records shall not be furnished to such patient or anyone authorized to act on the patient's behalf where the patient's attending physician or the patient's clinical psychologist has made a part of the patient's record a written statement that, in his opinion, the furnishing to or review by the patient of such records would be injurious to the patient's health or well-being. If any custodian of medical records denies a request for copies of records based on such statement, the custodian shall permit examination and copying of the medical record by another such physician or clinical psychologist selected by the patient, whose licensure, training and experience relative to the patient's condition are at least equivalent to that of the physician or clinical psychologist upon whose opinion the denial is based. The person or entity denying the request shall inform the patient of the patient's right to select another reviewing physician or clinical psychologist under this subsection who shall make a judgment as to whether to make the record available to the patient. Any record copied for review by the physician or clinical psychologist selected by the patient shall be accompanied by a statement from the custodian of the record that the patient's attending physician or clinical psychologist determined that the patient's review of his record would be injurious to the patient's health or well-being.

For additional information, please contact the Privacy Officer for the Winchester Fire & Rescue Dept, (540) 662-2298. A completed form MUST be hand delivered or mailed:

Winchester Fire & Rescue Department
Privacy Officer
P.O. Box 2998
Winchester, Virginia 22604